# Notice of Conversion Rights

**{Date of COBRA Letter}**

**To: {Name of COBRA Qualified Beneficiary EE}, {Name of COBRA Qualified Beneficiary Spouse}** and all covered dependents

**{Address of COBRA Qualified Beneficiary}**

***RE: Notice of Your Right to Convert to Direct Pay Medical Coverage***

**Expiration of Group Health Plan Continuation Coverage**

This notice is being sent to inform you that your COBRA coverage period will soon expire as you have completed the **{Months 18/29/36}** elected continuation coverage that resulted from the **{Enter qualifying event}** that occurred on **{Enter date of qualifying}**. Unless you cancel it earlier, on **{date coverage will expire}**, **{Employer Name}** will terminate your COBRA health coverage. Do not pay any additional premiums after the months that fall after **{date coverage will expire}.**

**Enrollment in Conversion Policy**

Upon receiving notification that your COBRA coverage has ended, **{Name of health plan employee is covered by}** will send you a **Conversion Letter**. The letter explains the right each qualified beneficiary has to convert to non-group direct pay coverage. You can enroll without waiting periods or coverage restrictions, as long as you do so within 63 days of the date your COBRA coverage ends. You are *not* eligible for conversion coverage if you lapse your COBRA coverage prior to the applicable month timeframe. It is your responsibility to apply for this coverage with **{Name of health plan employee is covered by}**. If you fail to contact **{Name of health plan employee is covered by}** then your option to enroll in the conversion policy may be lost.

**Questions:**

Should you have any questions regarding this notice, please contact **{employer contact},** at **{employer contact phone number},** Human Resources **{Employer Name}, {Employer Address}**